

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 8 Film G385 1/24/67 mh

01302

CERTIFICATE OF DEATH

01299

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Champ</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Champ</b> 19.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Herman Bloodsworth</b>		4. DATE OF DEATH <b>January 11, 1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1898 Nov. 3, 1969</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Somerset Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Bloodsworth</b>		14. MOTHER'S MAIDEN NAME <b>Cora Shores</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Lillian Bloodsworth, Champ, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>coronary arteriosclerosis</b> DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19__ to <b>1-11-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>1-10-67</b> 19__, and that death occurred at <b>2:30 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Everett Sutter</i> M.D.		22b. DATE SIGNED <b>1-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Everett Sutter MD</b>		22d. ADDRESS <b>Dames Quarter, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/14/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grace Episcopal</b>	23d. LOCATION (City or Town) (County) (State) <b>Mt. Vernon, Somerset Co.</b>
24. FUNERAL DIRECTOR <i>James Herman</i>		25a. REC'D BY REGISTRAR <b>Princess Anne, Md.</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

DATE **JAN 18 1967**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No. 01300

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>				c. LENGTH OF STAY IN 1b <u>19.1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>E.</u> Last <u>Gerald</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25, 1904</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaford Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Heathville, Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Brown</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-102371</u>			
17. INFORMANT <u>Leon Gerald</u> Address <u>Rt. 1, #96 Crisfield, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic Myocarditis</u> <u>1992</u> DUE TO <u>METASTATIC CARCINOMA OF LIVER AND LUNGS (PRIMARY UNKNOWN)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS.</u> <u>KNOWN</u> <u>2 WEEKS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE ARTERIOSCLEROT HEART DISEASE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/11</u> , 19 <u>63</u> , to <u>1/19</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>67</u> , and that death occurred at <u>5<sup>00</sup></u> P. M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Crisfield, Md.</u>				DATE SIGNED <u>1/21/67</u>			
ACTUAL SIGNATURE <u>C. N. Barr, Jr. D</u> M.D.							
PHYSICIAN'S NAME (Type) <u>A. N. BARR, M.D.</u>				<u>CRISFIELD, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/22/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Som. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Hall #235</u>				ADDRESS <u>Marion St., Md.</u>		24a. REC'D BY REGISTRAR <u>Charles Judge</u>	
DATE <u>JAN 24 1967</u>				24b. REGISTRAR'S SIGNATURE			



01304

CERTIFICATE OF DEATH

01301

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryl and</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital</b>		d. STREET ADDRESS <b>RFD Johnson's Creek Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Maude S. Justice</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1891</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>L. William Sterling</b>		14. MOTHER'S MAIDEN NAME <b>Melissa Dize</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-4698</b>	
17. INFORMANT <b>Oscar S. Justice, Jr.,</b>		Address <b>Crisfield, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic Myocarditis</b> DUE TO (b) <b>Terminal Pneumonia</b> DUE TO (c) <b>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus, Arteriosclerosis.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>qmk.</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 20, 1966</b> to <b>Jan 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-2-67</b> , 19____, and that death occurred at <b>1:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>A. N. Barr, M.D.</b>		22b. DATE SIGNED <b>1/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. N. Barr, M.D.</b>		22d. ADDRESS <b>Crisfield, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Md.</b>
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 9 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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*Topo Hydrographica*  
*Terminal Pinnatus*  
*Central Vascular Unit*

*Protein Synthesis Unit*

*Protein Synthesis Unit*

*Protein Synthesis Unit*

X



01305

## CERTIFICATE OF DEATH

01302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> c. LENGTH OF STAY IN 1b <b>15</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type of print) First <b>Andrew</b> Middle <b>Arthur</b> Last <b>Keyser</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1902</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>213-14-1571</b>	
17. INFORMANT <b>Mrs. Betty Windsor, Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Dilat of Ant Uterus</b> DUE TO (b) <b>Chronic Dilat right Chronic myocardial</b> DUE TO (c) <b>Acute of abdomen Malignant?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute of abdomen Peritoneal Cancer?</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-3-66</b> , 19 <b>66</b> , to <b>1-4</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan. 3</b> , 19 <b>67</b> , and that death occurred at <b>11:55</b> M. from causes and on the date stated above.			
22a. SIGNATURE <b>George G. Coulbourn</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>G. C. Coulbourn, M.D.</b>		22d. ADDRESS <b>Crisfield, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 7, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mariners Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Md.</b>
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

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FOR STATE HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01306

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01303

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Pocomoke</b> c. LENGTH OF STAY IN lb <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Pocomoke</b> d. STREET ADDRESS <b>RFD #1, Box 102</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>ROBERT</b> Last <b>LEE</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>14</b> Year <b>19 67</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 27, 1938</b>	9. AGE (In years last birthday) <b>28</b> yrs.	IF UNDER 1 YEAR Months <b>14</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>67</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Elwood Lee</b>			14. MOTHER'S MAIDEN NAME <b>Nellie Kersey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Nellie Kersey Lee</b> <b>RFD #1, Box 102 Pocomoke, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3220</b> IMMEDIATE CAUSE (a) <b>Acute alcoholism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury.</b>				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>C. G. Rawley</b> EXAMINER'S NAME (Type)		M.D. <b>C. G. Rawley</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>1/17/67</b> <b>Crisfield, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/19/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pocomoke Md.</b>
24. FUNERAL DIRECTOR <b>Wharton &amp; Savage</b> ADDRESS <b>New Church, Va.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

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01308

## CERTIFICATE OF DEATH

01307

01304

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>6 yrs 4 mos 19/77</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital</b>		d. STREET ADDRESS <b>114 Burton Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Julia A. Marshall</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>May 28, 1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>26</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tangier, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John D. Crockett</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Wilfred Sparrow, Same as 2. abcd above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Acute cardiac dilatation -</b> DUE TO (c) <b>Myocarditis Chronic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hr - minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/26/67</b> , to <b>6/19/67</b> , that (I) (we) last saw the deceased alive on <b>1/26/67</b> , and that death occurred at <b>6:15</b> , from causes and on the date stated above			
22a. SIGNATURE <b>C. G. Rawley</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>C. G. Rawley</b>		22d. ADDRESS <b>Crisfield, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 29, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Tylerton Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Tylerton, Md.</b>
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 31 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01308					01305									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <b>SOMERSET</b> MARYLAND					a. STATE <b>MD.</b> b. COUNTY <b>SOMERSET</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>116 S. 4th St.</b>									
c. LENGTH OF STAY IN 1b <b>Life</b>					d. STREET ADDRESS <b>Crisfield Md.</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At Home</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED			4. DATE OF DEATH			5. AGE			6. IF UNDER 1 YEAR					
(Type or print)			Month			Day			Year					
<b>GEORGE</b>			<b>Jan.</b>			<b>18</b>			<b>1967</b>					
7. SEX <b>M</b>			8. DATE OF BIRTH <b>Dec. 29 1900</b>			9. AGE (In years last birthday) <b>66</b> yrs.			10. IF UNDER 24 HRS. Months Days Hours Min.					
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			12. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>			13. BIRTHPLACE (County & State, or foreign country) <b>Crisfield Md.</b>			14. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
15. FATHER'S NAME <b>William Moore</b>					16. MOTHER'S MAIDEN NAME <b>Susan Parker</b>									
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					18. SOCIAL SECURITY NO.					19. INFORMANT Address <b>Ella D. Moore Crisfield Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>WITH PASSIVE CONGESTION</b> INTERVAL BETWEEN ONSET AND DEATH <b>Few Min.</b> <b>12 YEARS</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					20g. (County)					20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>9/12/1964</b> , to <b>1/18, 1967</b> , that (I) (we) last saw the deceased alive on <b>1/16, 1967</b> , and that death occurred at <b>6:27 P.M.</b> from the causes and on the date stated above.										22a. SIGNATURE <b>G.N. Barr, M.D.</b>		22b. DATE SIGNED <b>1/21/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>A.N. BARR, M.D.</b>					22d. ADDRESS <b>CRISFIELD, MD.</b>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>1/22/67</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>				
23d. LOCATION (City, town or county) <b>Crisfield</b>					23e. (State) <b>MD.</b>					24. FUNERAL DIRECTOR <b>ANTHONY E. WARD CRISFIELD MD.</b>				
24a. REC'D BY REGISTRAR <b>JAN 24 1967</b>					24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					24c. DATE				

01308

01308

Acute Myocardial Infarction  
Arteriosclerotic Heart Disease  
with Passive Congestion

15 Years

A.N. BARR, M.D.  
G.N. BARR, M.D.

CHICAGO, ILL.

11/2/57

11/2/57

11/2/57

11/2/57

X



FOR STATE  
HEALTH DEPT.

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01309		Item 8, Birth Certificate file 13019 one								01306	
1. PLACE OF DEATH a. COUNTY Somerset						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural (Kingston)				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingston Md.				19.1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vera			First Wright			Middle Shockley			4. DATE OF DEATH 1 26 19 67		
5. SEX f		6. COLOR OR RACE col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-67 34		9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Crisfield			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Brice Wright						14. MOTHER'S MAIDEN NAME Bertha Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-28-2536		17. INFORMANT Mother Bertha Wright, Kingston Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic carcinoma of cervix 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Everett Sutter MD						22. DATE SIGNED Somerset 1-27-67					
EXAMINER'S NAME (Type) Everett Sutter MD				Address (Street, city, town, or county) Somerset							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-29-67		23c. NAME OF CEMETERY OR CREMATORY House of Jacobb				23d. LOCATION (City, town or county) (State) Chance Md			
24. FUNERAL DIRECTOR ADDRESS Anthony E Ward, Crisfield Md.						25a. REC'D BY REGISTRAR JAN 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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(11/11/11)

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## CERTIFICATE OF DEATH

01307

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5 Days</b> c. LENGTH OF STAY in 1b <b>5 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield,</b> d. STREET ADDRESS <b>9 Cove Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>C</b> Last <b>Spires</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>31</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25, 1891</b>
9. AGE (In years last birthday) <b>75</b> YRS.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>9</b>	11. IF UNDER 24 HRS. Hours <b>4</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Station Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elizabeth City, N.C.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charlie Spires</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Barnes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>Addie Spires, Crisfield, Md.</b>	
17. INFORMANT <b>Addie Spires, Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>490X</b> DUE TO (c) <b>490X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 26, 1967</b> to <b>Jan 31, 1967</b> , that (I) (we) last saw the deceased alive on <b>1/31/67</b> 19 <b>67</b> , and that death occurred at <b>12:25</b> , from causes and on the date stated above			
22a. SIGNATURE <b>C. G. Rawley</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>C. G. Rawley, M.D.</b>		22d. ADDRESS <b>Crisfield, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Somerset Co. Md.</b>
24. FUNERAL DIRECTOR <b>James Hannon</b>		25a. REC'D BY REGISTRAR <b>Crisfield, Md.</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01307

CERTIFICATE OF DEATH

01310

April 25, 1951

Elizabeth City, N.C., U.S.

Mollie Barnes

White Plains, Connecticut, U.S.

Married

Service Station Manager

Charles Jones

Feb. 2, 1952 - Whitefield Cemetery

Whitefield, N.H.